TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
West Texas Rehabilitation Center

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-15-2682-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 21, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Since these charges which were originally billed to commercial insurance became work related and the adjuster said that they will be paid. I think that we should be compensated for our services."

Amount in Dispute: $500.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reprocessed the bills and payment has been made."

Response Submitted by: Broadspire, P.O. Box 14351, Lexington, KY 40512-4351

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2014 through August 5, 2014	Physical Therapy Services	$500.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas medical fee guideline
   - W1 – Workers' compensation jurisdictional fee schedule adjustment

- 631 – PT, OT, OR SP code present without required non-payable G code
- 246 – This non-payable code is for required reporting only
- 18 – Exact duplicate claim/service

Issues

1. What services did the insurance carrier pay?
2. Is the requestor entitled to additional reimbursement for the services that were not reimbursed by the insurance carrier?

Findings

1. This dispute relates to physical therapy services of which the requestor lists many dates of service as unpaid. In their response to the request for Medical Fee Dispute Resolution, the carrier states, "We have reprocessed the bills and payment has been made." Review of the submitted explanation of benefits have found the following payments made by the carrier.

Date of service in dispute	Submitted Code	Billed Amount	Date of EOB	Payment amount	Maximum Allowable Reimbursement
April 15, 2014	97003 GO	200.00	May 3, 2015	$126.88	$126.88
April 15, 2014	G8984 GO CM	.01	Functional Reporting Code Non-Payable	N/A	N/A
April 15, 2014	G8985 GO CK	.01	Functional Reporting Code Non-Payable	N/A	N/A
April 17, 2014	97140 GO 59	50.00	May 14, 2014	$44.85	$34.64
April 17, 2014	97110 GO	50.00	May 14, 2014	$48.01	$48.01
April 18, 2014	97140 GO	50.00	May 14, 2014	$44.85	$44.85
April 22, 2014	97110 GO	50.00	May 14, 2014	$48.01	$48.01
April 24, 2014	97110 GO	50.00	May 14, 2014	$48.01	$48.01
April 28, 2014	97110 GO	50.00	June 2, 2014	$48.01	$48.01
May 2, 2014	97110 GO	50.00	June 11, 2014	$48.01	$48.01
May 6, 2014	97110 GO	50.00	June 11, 2014	$48.01	$48.01
May 13, 2014	97110 GO	50.00	June 11, 2014	$48.01	$48.01
May 15, 2014	97016 GO	35.00	June 11, 2014	$28.37	$28.36
May 15, 2014	97110 GO	50.00	June 11, 2014	$48.01	$48.01
May 20, 2014	97110 GO	50.00	June 10, 2014	$48.01	$48.01
May 22, 2014	97004 GO 59	200.00	June 19, 2014	$78.73	$78.73
May 22, 2014	97110 GO	50.00	June 19, 2014	$48.01	$48.01
May 27, 2014	97110 GO	50.00	June 19, 2014	$48.01	$48.01
June 4, 2014	97110 GO	50.00	June 23, 2014	$48.01	$48.01
June 19, 2014	97110 GO	50.00	July 2, 2014	$48.01	$48.01
June 26, 2014	97016 GO	35.00	May 8, 2015	$28.37	$28.37
June 26, 2014	G8984 GO CJ	.01	Functional Reporting Code Non-Payable	N/A	N/A
June 26, 2014	G8985 GO CI	.01	Functional Reporting Code Non-	N/A	N/A

			Payable		
June 26, 2014	97004 GO 59	200.00	May 8, 2015	$78.73	$78.73
June 26, 2014	G8984 GO CK	.01	Functional Reporting Code Non-Payable	N/A	N/A
June 26, 2014	G8985 GO CJ	.01	Functional Reporting Code Non-Payable	N/A	N/A
July 2, 2014	97110 GO	50.00	Denied as duplicate		
July 2, 2014	97140 GO 59	50.00	May 8, 2015	$44.85	$34.64
July 2, 2014	97110 GO	50.00	Denied as duplicate		
July 3, 2014	97110 GO	50.00	May 8, 2015	$48.01	$48.01
July 3, 2014	97140 GO 59	50.00	May 8, 2015	$44.85	$44.85
July 3, 2014	97110 GO	50.00	Denied as duplicate		
July 3, 2014	97140 GO 59	50.00	Denied as duplicate		
July 8, 2014	97110 GO	50.00	August 6, 2014	$48.01	$48.01
August 5, 2014	97004 GO 59	200.00	May 8, 2015	$78.73	$78.73
August 5, 2014	G8984	.01	Functional Reporting Code Non-Payable	N/A	N/A
August 5, 2014	G8985	.01	Functional Reporting Code Non-Payable	N/A	N/A

Review of the submitted documentation finds the insurance carrier issued payment for the majority of the disputed dates of service. The following services were denied by the insurance. As a result, the division will review the remaining services that were not reimbursed by the insurance carrier. The Division finds the following:

July 2, 2014, the requestor billed for 2 units of CPT Code 97110-GO. Review of the medical documentation finds that requestor documented one unit of CPT Code 97110-GO. The insurance carrier reimbursed the requestor for one unit, as a result reimbursement cannot be recommended for the additional (2nd unit).

July 3, 2014, the requestor billed for 2 units of CPT Code 97110-GO and two units of CPT Code 97140-GO. Review of the medical documentation finds that the requestor documented one unit of CPT Code 97110-GO and one unit of CPT Code 97140-GO. The insurance carrier reimbursed the requestor for these charges. As a result, the requestor is not entitled to additional reimbursement for the 2nd unit of CPT Code 97110-GO and the 2nd unit 97140-GO.

2. Based on the pertinent documentation submitted by both parties, the Division finds no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.